

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29CY	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER COURTYARDS COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 EAST WALKER STREET FULTON, MS 38843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey investigation, CI MS# 17839 at the facility from 6/29/2021 through 6/30/2021. The SA did not substantiate the complaint and cited no deficiencies. However, the facility remains in non-compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements due to deficiencies cited on the previous survey. The facility had a census of 55 at the time of the complaint survey with a license for 66 bed capacity.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE